

MAY 13 1940

State File No.

Registration District No. 431

Primary Registration District No. 5595

Registrar's No. 51

I. PLACE OF DEATH:

(a) County JOHNSON  
(b) City or town Rural, Simpson Mo  
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2  
(Specify whether)

In this community 35 years.  
(years, months or days)

3. (a) PRINT FULL NAME AUGUST WALKEN HORST

8. (b) If veteran, name war No  
8. (c) Social Security No.

4. Sex Male  
5. Color or race white  
6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Caroline Walkenhorst  
6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased JUNE 26 1866  
(Month) (Day) (Year)

8. AGE: Years 73 Months 9 Days 9  
If less than one day hr. min.

9. Birthplace Germany  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

12. Name FRED WALKENHORST

13. Birthplace GERMANY  
(City, town, or county) (State or foreign country)

14. Maiden name ELIZABETH HELLING

15. Birthplace GERMANY  
(City, town, or county) (State or foreign country)

16. (a) Informant CLEM REISTERER

(b) Address CONCORDIA MO

17. (a) Burial (b) Date thereof APR 8 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Matthew Cemetery

18. (a) Signature of funeral director F. S. James

(b) Address Concordia Mo  
19. (a) April 6-40 (b) Eva Lentz  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Johnson  
(c) City or town Rural Concordia Mo  
(If outside city or town limits, write "RURAL")

(d) Street No. D  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 59 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 5  
year 1940 hour 6:50 minute P.M.

21. I hereby certify that I attended the deceased from JUNE 4 - 40  
19 to 4-5-1940

that I last saw him alive on 4-2-40  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Bright's Disease ?

Due to

Due to

Other conditions  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur?  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

391  
While at work (Specify type of place) (e) Means of injury

28. Signature W. J. [Signature] (M. D. or other)

Address W. J. [Address] Date signed 4-6-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

172

RECEIVED

RECEIVED  
District Health Officer No. 8,  
District No. 8  
Date Filed 5-9-40

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by me

Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed E. S. James

Licensed Embalmer No. 2058

P. O. Address Council Bluffs, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 15-271

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 431

Primary Registration District No. 5395-

Registrar's No. 27

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:  
(a) County Johnson  
(b) City or town Simpson, Tenn  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution  
In this community... (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State... (b) County...  
(c) City or town... (If outside city or town limits write "RURAL")  
(d) Street No... (If rural, give location)  
(e) If foreign born, how long in U. S. A. ... years.

3. (a) PRINT FULL NAME August Walker Horst  
3. (b) If veteran, name war... 3. (c) Social Security No...

20. DATE OF DEATH Month 4 day 2 year 19... hour... minute... M.

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m  
6. (b) Name of husband or wife... 6. (c) Age of husband, or wife, if alive... year

21. I hereby certify that I attended the deceased from... 19... to... 19... that I last saw h... alive on... and that death occurred on the date and hour stated above.  
Immediate cause of death Bright's Disease (CHRONIC)

8. AGE: Years 73 Months 9 Days 7 If less than one day hr min.

Due to Cause not known -  
Due to 131

9. Birthplace (City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation

Major findings: Of operations

11. Industry or business

Of autopsy

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (b) (Date received local registrar) (Registrar's signature)

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify)  
(b) Date of occurrence  
(c) Where did injury occur? (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
While at work? (Specify type of place) (e) Means of injury

23. Signature M. F. McKinney (M. D. or other) Address Harrisonburg

SUPPLEMENTAL

